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Obstetrics | Gynecology | Urogynecology | Minimally Invasive Surgery | Infertility

Authorization for Release of Confidential Health Information

1. Individual Information:

Printed Name of Patient____ Date of Birth__________________________________

Address ____

Phone Number ____

2. Information may be disclosed by:

Name of Organization or person releasing information ____

Address ____

Phone Number _______________________________________ Fax Number ____

3. Information may be disclosed to:

Name of Organization or person receiving information ____

Address ____

Phone Number ______________________________________ Fax Number ____

4. What information do you want disclosed? (Choose ONE option, copy fees may apply)

[ ] Information from the most recent 2 years of visits

[ ] All information from date ____ /____ /_____ to date ____ /____ / ____

[ ] Information regarding specific treatment, condition, or other (specify):

____

5. Why are you asking for this health information to be released? (Choose ONE option)

Attorney   Insurance   Doctor   Medical Leave   Personal   Other (specify) _________________________________

6. Authorization: The medical information to be released as specified above may include any of the following information as it pertains to the request: laboratory reports, x-ray reports, operative notes, and information regarding the testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness. By my initials and signature, I give my specific authorization for this information to be released. ___________ **(initial)**

[ ] Mental Health   [ ] Developmental Disabilities   [ ] Alcohol/Substance Abuse   [ ] HIV/AIDS   [ ] Other_________________

7. Expiration: This authorization expires in 90 days from the date signed or on the date or event indicated here:

____

8. Signature: ____ Date**:** _____ /_____ /______

9. Signature of Witness: ____ Date: _____ /_____ /_____